DIABETES ACTION PLAN

For use of this form see MEDCOM Circular 40-8

SECTION I - MY DIABETES SELF-MANAGEMENT GOALS

1. SMALL STEPS FOR CHANGE - SELECT AND INITIAL 3 GOALS FROM THE LIST BELOW

(INITIALS) **I WILL:**

_____ Monitor my blood sugar _____ times per day, _____ times per week.
_____ Record my blood sugar in a record book.
_____ Bring my blood glucose meter to every visit.
_____ Eat meals and snacks at designated times.
_____ Use carbohydrate counting to plan my meals.
_____ Read labels for carbohydrate and fat content.
_____ Control my portion sizes.
_____ Build more activity into my day *(by walking, parking further away, taking the stairs)*:

_____

_____ Enroll in a smoking cessation program.
_____ Monitor my blood pressure _____ times per _____
_____ Wash, dry, and examine my feet daily.

2. MEDICATION LIST

I will become familiar with and take the following medications as directed by my health care provider:

3. MY PERSONAL BEST

DIABETES	MONITORS FOR	ACCEPTABLE RANGE	MY RANGE	GOAL FOR NEXT VISIT(S) Date:	Date:
BMI	Body weight				
Blood pressure	Work of the heart				
HbA1c	Average 3 month blood sugar				
LDL (lipid)	Heart disease				
Urine Protein	Kidney disease				

SECTION II - MY DIABETES SELF-MANAGEMENT FOLLOW-UP PLAN

I WILL HAVE AN:	DATE	DATE	DATE	DATE
Annual eye exam				
Annual foot assessment				
Annual flu vaccine				
Pneumonia vaccine				

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

_____
(Date Signed)

_____
(Patient's Signature)

_____
(Provider's Signature)

DIABETES SELF MANAGEMENT ACTION PLAN

1. HYPERGLYCEMIA - If I recognize signs/symptoms of hyperglycemia:

- Fatigue
- Excessive thirst
- Frequent urination
- Blurred vision

I will:

- Drink plenty of non-caloric fluids
- Check my blood sugar and ketones
- Adjust my meal plan and activity level
- I will call my primary care provider if my blood sugar is > _____ (*default value is 250*) three times in a row within _____ hours

And I will consider the cause:

- Forgetting to take diabetes medication
- Overeating
- Infection/Illness
- Stress
- Inactivity

2. HYPOGLYCEMIA - If I recognize signs/symptoms of hypoglycemia:

- Weakness
- Rapid heart beat
- Light-headedness or confusion
- Shakiness
- Sweating

I will:

- Eat a snack containing fast-acting carbohydrates (*e.g., juice, cola, skim milk, crackers*)
- Re-check blood sugar in 15 minutes; if < _____ , eat an additional fast-acting carbohydrate
- Eat a meal or snack within 30 minutes

And I will consider the cause:

- Delaying meals
- Not eating enough food
- Too much diabetes medication
- Too much exercise

3. SICK DAY RULE - When I am sick:

I will:

- Continue to take my diabetes medication
- Monitor my blood sugar every _____ hours and if > _____ test for ketones
- Eat the usual amount of meals and snacks divided into smaller proportions
- Drink fluids frequently (*8 ounces per hour while awake*)

And I will seek medical assistance if I have:

- Blood sugar > _____ or double the range set by my health care provider
- Blood sugar < _____ that does not improve after eating a meal or snack
- Fever of 101 degrees or higher
- Nausea and vomiting, especially if no food or fluid intake for more than 5 hours
- Symptoms of shakiness, lightheadedness, sweating, rapid heart rate that does not improve after eating a meal or snack
- Any problems with my feet (*burns, blisters, swelling, bruising or discoloration, bleeding, or oozing of fluid*)

_____ *(Patient's Signature)*

_____ *(Date Signed)*

_____ *(Provider's Signature)*